

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 010888	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 06/27/2013
NAME OF PROVIDER OR SUPPLIER STERLING HOUSE OF RICHMOND		STREET ADDRESS, CITY, STATE, ZIP CODE 3700 S A ST RICHMOND, IN 47374		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{R 000}	<p>INITIAL COMMENTS</p> <p>This visit was for a Post Survey Revisit (PSR) to the Investigation of Complaint IN00127928 completed on May 2, 2013.</p> <p>Complaint IN00127928 -- Corrected.</p> <p>Survey date: June 27, 2013</p> <p>Facility number: 010888 Provider number: 010888 AIM number: N/A</p> <p>Survey team: Penny Marlatt, RN</p> <p>Census bed type: Residential: 39 Total: 39</p> <p>Census payor type: Other: 39 Total: 39</p> <p>Sample: 3</p> <p>Sterling House of Richmond was found to be in compliance with 410 IAC 16.2 in regard to PSR to the Investigation of Complaint IN00127928.</p> <p>Quality review 7/02/13 by Suzanne Williams, RN</p>	{R 000}		

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TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

QD3212

If continuation sheet 1 of 1